

# Equality Impact Assessment

Summary, tool and guidance for policy makers



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# Equality Impact Assessment

Summary, tool and guidance for policy makers

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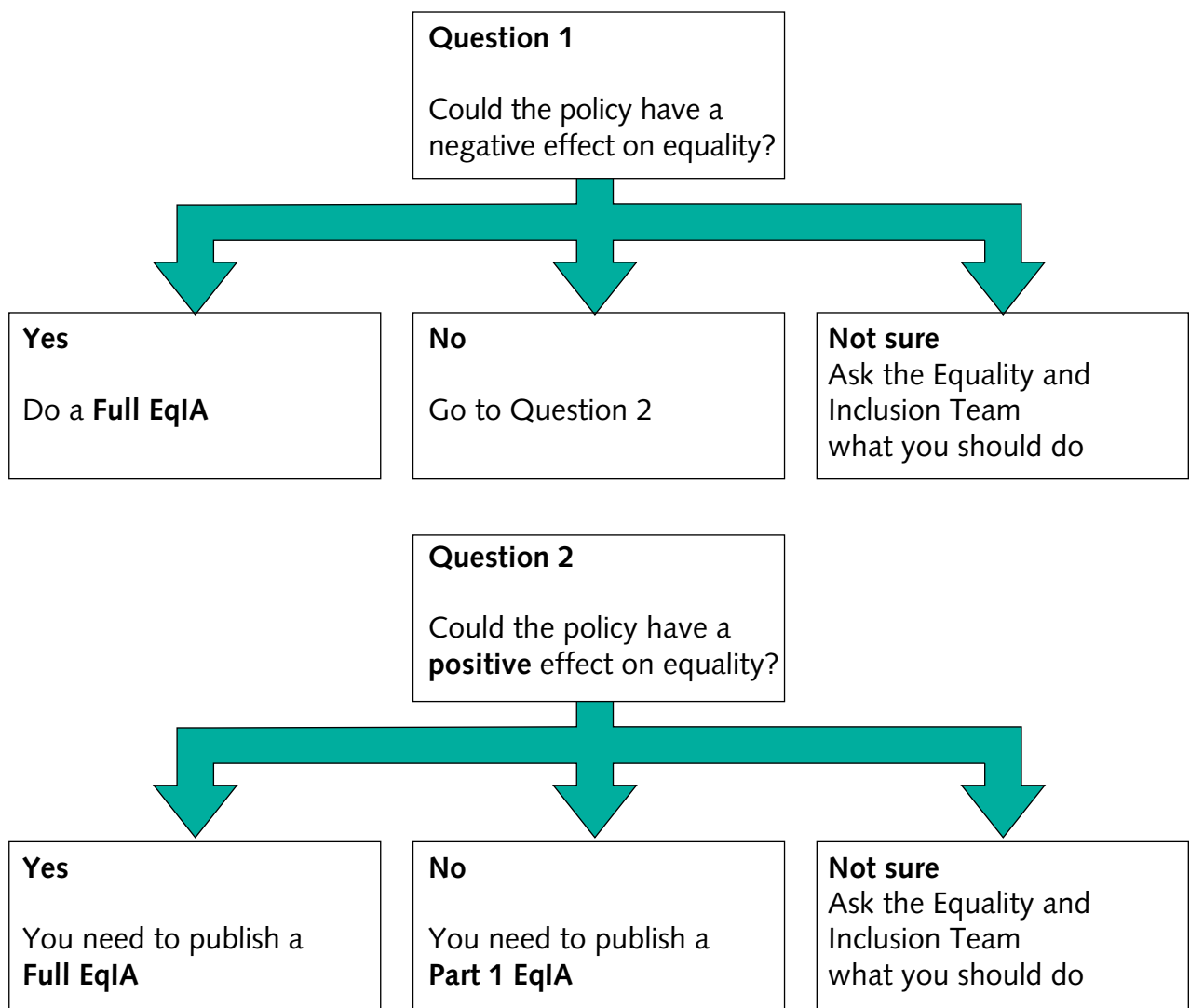
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# Do you need to do an Equality Impact Assessment?

An Equality Impact Assessment (EqIA) is a process which helps you look at what impacts a new or existing policy is likely to have on different groups of people.

To decide whether you need to do an EqIA, ask yourself 2 questions:



For more information on doing a **Part 1 EqIA** see page 14.

For more information on doing a **Full EqIA** see page 19.

# Section 1: Summary

1. By law, public organisations like the Department of Health (DH) must:
  - encourage equality and get rid of discrimination
  - help different groups of people to get on well together
  - get rid of harassment
  - involve people in decisions about their health and social care and their access to services.

The **NHS Constitution** says that the NHS provides a comprehensive service to all, whatever their gender, race, disability, age, sexual orientation, religion or belief. It has a duty to everyone it serves and must respect their human rights. The NHS also has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. DH uses **Equality Impact Assessments** (EqIAs) and the **DH Single Equality Scheme** to help us obey the law and to reduce the health inequalities in England between:
  - people from different **ethnic** backgrounds
  - people with **disabilities**
  - **men and women** (including **transgendered** people)
  - people with different **sexual orientations**
  - people in different **age** groups
  - people with different **religions or beliefs**
  - people from different **social and economic** ('socio-economic') groups.

Policy makers **must** check all new (and in time, all existing) policies for their likely impact on people in each of these groups.

3. You must base your decisions about what impact a policy is likely to have on these groups on **evidence** you have.

You need to assess **how much** your policy is likely to affect each of these groups. This is called **screening**.

- If screening shows that the policy will **not** have a major impact on any of the groups, you will only need to publish your decision as a **Part 1 EqIA**.
- If you find that your policy could have a major impact (either negative or positive), you must carry out and publish a **Full EqIA**.

An EqIA is not an add-on at the end of the process. The EqIA should help to **inform and strengthen your policy** while you develop it and while you are carrying it out.

4. The NHS is for everyone, and provides care based on need. However, this does not guarantee that everyone has equal access to services or experiences equal outcomes. For example:

### Access

- A person whose first language is not English may need information in a different language if they are to have an equal chance of understanding it.
- A person with a sight or hearing impairment may need information in a different format.
- Buildings need to be accessible to everyone.

### Differences in take-up and outcome

- Men between 16 and 44 years old are 50% less likely to visit a GP than women. This often leads to late diagnosis.
- Men are twice as likely as women to develop and die from the 10 most common cancers that affect both sexes.
- We need to consider how to target services more specifically at men.

This booklet has **3** sections.

**Section 1** is a **summary** of what EqlAs are and has a **flow-chart** that shows how to carry out an EqlA.

**Section 2** is a tool for policy makers with **templates** for each stage of the process.

**Section 3** has more **guidance** on filling out the templates.

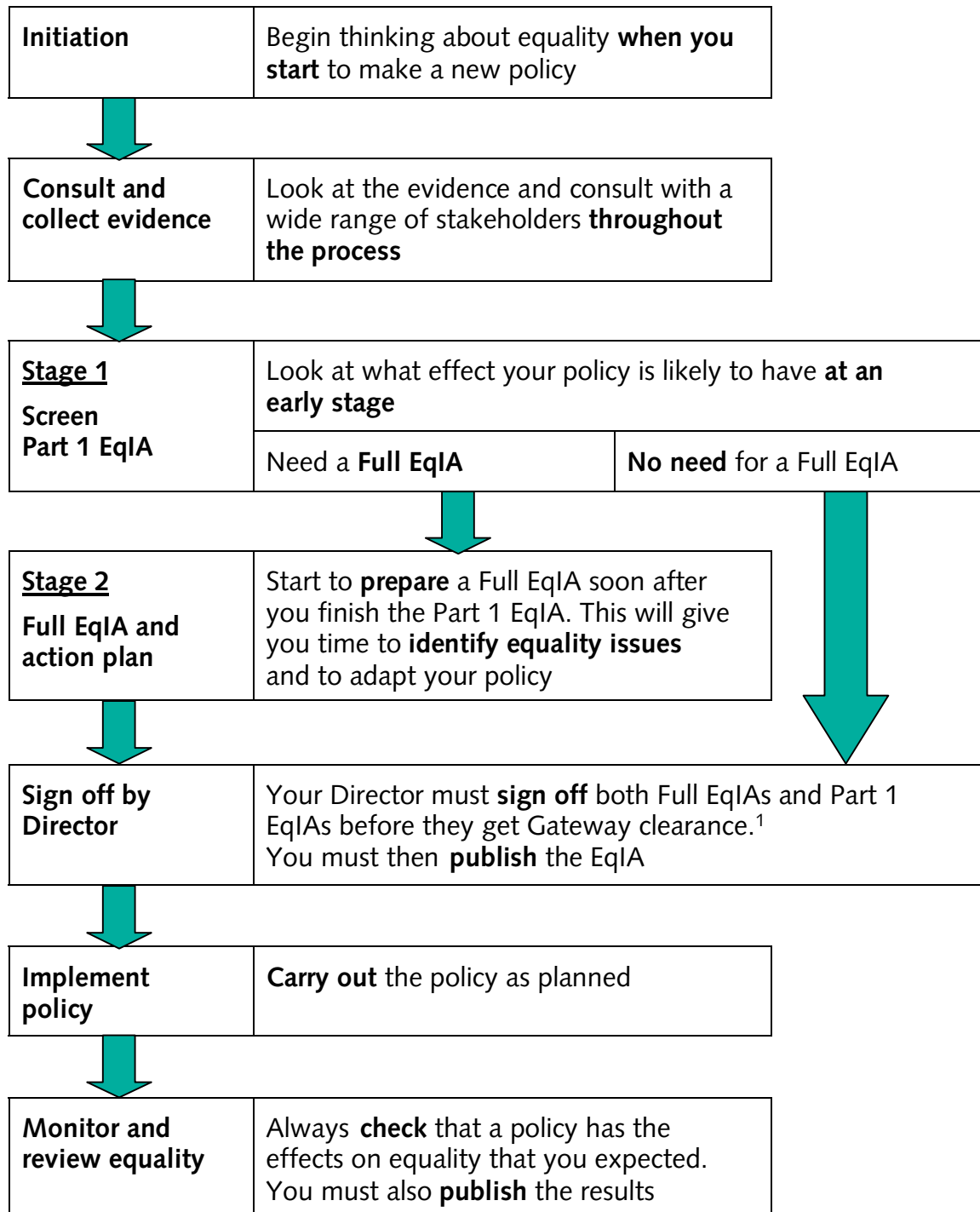
There are also **2** Annexes.

**Annex 1** is a style guide to help you write your EqlAs.

**Annex 2** gives answers to **11** frequently asked questions (FAQs).

## How to carry out an Equality Impact Assessment

This flow-chart shows the process you need to go through for each new policy.



<sup>1</sup> Gateway clearance is the approval needed to publish an NHS document.

# Section 2: Equality Impact Assessment Tool

This section is a tool for policy makers. It has templates you can use to help you through each stage of the process.

## Introduction

The NHS exists to improve health and wellbeing for people in England.

It is for everyone, and provides care based on need.

However, this does not guarantee that everyone has equal access to services or experiences equal outcomes.

**There are inequalities between:**

- **men and women**
- **disabled and non-disabled** people
- people from different **ethnic** backgrounds
- people with different **sexual orientations**
- people in different **age** groups
- people with different **religions or beliefs**
- people from different **social or economic** (socio-economic) groups.

DH needs to make sure its policies really do improve health and social care.

We need to understand the impact our policies have on each of these groups of people.

To help us do this, you need to assess **each of your policies** for the impact it will have on **each group**.

## Why Equality Impact Assessment?

By law, public organisations like DH must carry out and publish EqlAs for all its policies and programmes about:

- disability
- ethnicity
- gender and gender identity (including transgendered people).

DH has also decided to carry out and publish EqlAs for:

- age
- sexual orientation
- religion or belief
- socio-economic disadvantage.

## About Equality Impact Assessment

### Principles

These are the **principles** on which we base our commitment to equality:

- **getting rid of** illegal or unreasonable **discrimination and harassment**
- **encouraging equality**
- **helping** different groups of people to get on well together to **improve community relations**
- **encouraging positive attitudes towards disabled people**
- **taking account of a person's disabilities**, even if this means treating them more favourably than other people
- **involving people in decisions** about their health and social care and their access to services.

An EqlA looks at what effect a DH policy is likely to have on each of these principles.

## Using the results

Carrying out an EqlA is a vital part of policy making and management.

You should use an EqlA to influence:

- the decisions you make
- how you carry out your decisions.

## Evidence

You should base your EqlAs on **strong evidence**.

Lack of evidence is **not** an excuse to do nothing. If you do not have enough evidence, you need to think about how to get it.

## Other measures

EqlAs are part of a broad range of measures to make sure that our policies always meet high standards.

You can find out more about how EqlAs fit alongside other assessments like Impact Assessments in **Annex 2**.

## Procurement

You must also think about equality whenever you procure goods or services.

This is because meeting equality duties is usually the responsibility of the public body that issues the contract.

DH's **Commercial Operating Model** explains our inclusive approach to procurement.

(Contact the Procurement, Investment and Commercial Division (PICD) (formerly PCoE) through **Delphi**, the DH intranet, for more information.)

## Policy making

An EqlA is not simply a document written at the end of the policy process. If you use it properly, an EqlA will help you make and strengthen a policy throughout the policy-making process.

When developing a policy, from the start you need to make sure it will deliver as much equality as possible. To do this you need to:

- gather all the evidence
- write the policy in a way that addresses the needs of all the different communities and groups
- consult with diverse groups and involve disabled people.

**This document tells you how to:**

- make sure a policy will deliver as much equality at service level as possible
- write an EqIA which meets the legal requirements.

You can find out more about the legal requirements through **Delphi** or online at [www.dh.gov.uk/equality](http://www.dh.gov.uk/equality)

#### Help and advice

If you need help or advice, please contact your Equality Policy Partner or email [EqIA@dh.gsi.gov.uk](mailto:EqIA@dh.gsi.gov.uk)

## Step-by-step guide to writing an Equality Impact Assessment

### Stage 1: Screening

First you need to **screen** your policy to decide if you need to do a **Full EqIA**. This means looking at what impact your policy is likely to have on different groups of people.

To help you do this there is:

- a template to fill in on pages 15–18
- guidance on language and style in **Annex 1**.

#### Proportionality

As part of the screening process you need to look at **proportionality**. This means deciding if any **negative** or **positive** impact on equality is likely to be **significant**, and for which groups of people. You may, for instance, decide that a policy will only affect a very small group of people.

You will usually be working on a piece of **national policy** or guidance. This may mean that an EqIA will need to be carried out at a **local level**.

If this is the case, you need to make sure that:

- the policy is **flexible** enough to be used in different ways at a local policy level and at a clinical level
- there are **systems in place** so that the people carrying out the policy can analyse its impact on equality. For instance, you could include advice in any guidance you send out that they will need to do a local EqIA before the policy is put into practice.

#### **Help and advice**

If you have any questions about **proportionality**, please ask your Equality Policy Partner for advice or email **EqIA@dh.gsi.gov.uk**

### **Part 1 Equality Impact Assessment**

If you decide that your policy does not need a **Full EqIA**, you must:

- record your decision
- include all the evidence
- show how you will monitor and review the situation.

This document will then be published as a **Part 1 EqIA**.

If your screening shows that you need to do a **Full EqIA**, you must move on to Stage 2: Full Equality Impact Assessment (see page 19).

## Screening template (Part 1 EqIA)

This template is to help you to screen your policy.

Please fill in the boxes and delete the guidance notes (GN) in the tint boxes when you are finished.

<b>Title of policy:</b>
<b>Short description of policy:</b>
<b>GN:</b> The description should be around 300 words and include the aims and objectives of the policy.
<b>Negative impact</b>
How could the policy have a <b>significant</b> negative impact on equality in relation to each area?
1. Age
2. Disability
3. Ethnicity
4. Gender (including transgendered people)
5. Religion or belief

6. Sexual orientation
7. Socio-economic
<p><b>GN:</b> You must assess <b>each</b> of the 7 areas separately and consider how your policy may affect people's human rights.</p> <p><b>You need to ask yourself:</b></p> <p>Will the policy create any <b>problems</b> or <b>barriers</b> to any community or group? <b>Yes/No</b></p> <p>Will any group be <b>excluded</b> because of the policy? <b>Yes/No</b></p> <p>Will the policy have a negative impact on <b>community relations</b>? <b>Yes/No</b></p> <p>If the answer to <b>any</b> of these questions is <b>Yes</b>, you must prepare a <b>Full EqIA</b>.</p>
<b>Positive impact</b>
<p>Could the policy have a <b>significant</b> positive impact on equality by reducing inequalities that already exist?</p> <p>Explain how will it meet our duty to:</p>
1. Promote <b>equal opportunities</b>
2. Get rid of <b>discrimination</b>
3. Get rid of <b>harassment</b>

4. Promote <b>good community relations</b>
5. Promote <b>positive attitudes</b> towards disabled people
6. Encourage <b>participation</b> by disabled people
7. Consider <b>more favourable treatment</b> of disabled people
8. Promote and protect <b>human rights</b>
<b>GN:</b> If the policy could affect <b>any</b> of these 8 duties, you must prepare a <b>Full EqIA</b> .

<b>Evidence</b>
What is the evidence for your answers to the above questions?
What does available research say?
What further research or data do you need to fill any gaps in your understanding of the potential or known effects of the policy?
Have you thought about commissioning new data or research?
<b>GN:</b> See <b>section 3</b> for advice on how to find and analyse the evidence.

**GN:** You need to look at and think about:

- quantitative research
- qualitative research
- national evidence
- international evidence
- results of any consultations you have carried out.

### Screening assessment

Now that you have looked at the evidence, do you think that the policy needs a **Full EqIA**? **Yes/No**

**GN:** if your answer is **Yes**, see **Annex 2** for advice on how to write your **EqIA**.

### Next steps

**GN:** If you need to do a **Full EqIA**, go to **Stage 2: Full Equality Impact Assessment** (page 19).

If you do **not** need to do a **Full EqIA**:

What else might you need to do to make sure the policy **promotes equality** and **gets rid of discrimination**?

**GN:** This could be things like making sure that local services know they will need to publish their own EqIAs.

How will you **monitor** the situation as the policy develops and takes effect?

What **further research** do you need?

**GN:** Once you have answered these questions, you will need to:

- ask your Director to sign off the document
- publish the document
- keep it as a record of your **Part 1 EqIA**
- send a copy to the **Equality and Inclusion Team**.

## Stage 2: Full Equality Impact Assessment

You **must** carry out a **Full EqIA** if your screening shows that a policy, programme or practice could have:

- a significant **negative** impact
- a significant **positive** impact
- **both** significant negative and positive impacts.

There is a template to help you do this on pages 21–28.

### Action plan

You also need to prepare an **action plan**. You should base your action plan on:

- the evidence you find to support your decisions
- the challenges you identify
- the opportunities you identify.

There is an action plan template to help you do this on page 29.

### You may find it helpful to:

- look at the short **unofficial history of EqIAs** in **Annex 4** in the mainstream document
- look at other recent EqIAs published by DH on our website **[www.dh.gov.uk/equality](http://www.dh.gov.uk/equality)**
- remind yourself of the **principles** on which we base our commitment to equality:

### Our principles

- **getting rid of illegal or unreasonable discrimination and harassment**
- **encouraging equality**
- **helping** different groups of people to get on well together to **improve community relations**
- **encouraging positive attitudes towards disabled people**
- **taking account of a person's disabilities**, even if this means treating them more favourably than other people
- **involving people in decisions** about their health and social care and their access to services.

## Full Equality Impact Assessment template

This template is to help you to write your Full EqIA.

Please fill in the boxes and delete the guidance notes (GN) in the tint boxes when you are finished.

<b>Title of policy:</b>
<b>Description of policy:</b>
<b>GN:</b> The description should include: <ul style="list-style-type: none"> <li>• a summary of the policy's aims</li> <li>• intended outcomes</li> <li>• an explanation of how the policy fits into DH's strategic objectives.</li> </ul>
<b>Evidence – Sources of evidence</b>
How is the policy likely to affect the <b>promotion of equality</b> and the <b>elimination of discrimination</b> in <b>each</b> of the groups?
Age
Disability
Ethnicity
Gender (including transgender)

Religion or belief
Sexual orientation
Socio-economic
How will the policy meet the needs of <b>different communities</b> and groups?
Age
Disability
Ethnicity
Gender (including transgender)
Religion or belief
Sexual orientation
Socio-economic

Give details of any <b>consultation</b> that has already been done which is relevant to this policy.
Age
Disability
Ethnicity
Gender (including transgender)
Religion or belief
Sexual orientation
Socio-economic
Give examples of existing <b>good practice</b> in this area, for example measures to make it easier for people in particular groups to influence policy.
Age
Disability

Ethnicity
Gender (including transgender)
Religion or belief
Sexual orientation
Socio-economic
<p><b>GN:</b> List the main sources of evidence on <b>each</b> group – both <b>quantitative</b> and <b>qualitative</b>.</p> <p>Remember to consider how your policy may affect people’s human rights.</p> <p><b>Qualitative</b> evidence may include comments and opinions from stakeholders as well as academic research.</p> <p>See <b>section 3</b> for more advice on what information to include.</p>

Evidence – Key facts
How is the policy likely to affect the <b>promotion of equality</b> and the <b>elimination of discrimination</b> in <b>each</b> of the areas?
Age
Disability
Ethnicity
Gender (including transgender)
Religion or belief
Sexual orientation
Socio-economic
<p><b>GN:</b> Give a selection of key facts relevant to <b>each</b> area.</p> <p>If there is little or no evidence, say what you will do to find some evidence and give examples of the types of evidence you might find.</p>

<b>Challenges and opportunities</b>
What measures does the policy include, or what could it include, to address existing patterns of <b>discrimination, harassment or inequality</b> ?
What impact will the policy have on <b>helping different groups of people</b> to get on well together to <b>improve community relations</b> ?
If the policy is likely to have a <b>negative</b> impact, what are the reasons?
What <b>practical changes</b> will help reduce any adverse impact on particular groups?
What will be done to <b>improve access</b> to, and <b>take-up</b> of, services and <b>understanding the policy</b> ?
What can you do to <b>promote equality</b> and <b>eliminate discrimination</b> when you procure goods and services?
<b>GN:</b> You need to consider how the policy could reduce or remove existing inequalities when answering these 6 questions.
<b>Equality Impact Assessment</b>
Please give a summary of your findings.
<b>GN:</b> We suggest that you choose, adapt and explain one of the statements from page 36. If you choose statement F, you will need to seek legal advice.

### Action plan

Please give an outline of your action plan based on the challenges and opportunities you have identified.

**GN:** Your action plan could include:

- Plans that are already under way or that you are already thinking about to address the **challenges** and **priorities** you have identified.
- Arrangements for continued **discussion** and **involvement** with stakeholders.
- Arrangements for **monitoring** and **evaluating** the policy for its impact on different groups throughout the policy-making process and as the policy is carried out.
- Arrangements for ensuring that any **pilot projects** are evaluated and take account of issues described in the assessment, and that they are assessed to make sure they are having the intended impact.
- Arrangements for discussing how far you can take account of the issues in the assessment with other agencies, service providers, non-departmental public bodies and regulatory bodies.
- Arrangements for ensuring that your relevant **colleagues** are **made aware** of the assessment.
- Arrangements to make sure the assessment contributes to reviews of DH's Single Equality Scheme.
- Arrangements for **disseminating information** about the assessment to all relevant **stakeholders** who will be implementing the policy.
- Arrangements for improving the body of **evidence** you have.

For the record
Name of person who carried out the EqIA:
Date EqIA was completed:
Name of Director/Director General who signed off the EqIA:
Date EqIA was signed off:
<p><b>GN:</b> These details are for the record only, and <b>not</b> for publication.</p> <p>All EqIAs must be signed off at Director level before they are published.</p> <p><b>Directors</b> must be sure that you have:</p> <ul style="list-style-type: none"><li>• <b>consulted</b> and <b>involved</b> stakeholders from each group</li><li>• gathered all the <b>relevant evidence</b></li><li>• have an <b>action plan</b>. There is guidance about creating an action plan on page 19.</li></ul>

### Action plan template

This template is to help you make your action plan.

You might want to change the categories in the first column to reflect the actions needed for each policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
Data collection and evidence			
Assessment and analysis			
Procurement and partnerships			
Monitoring, evaluating and reviewing (including publishing the results)			

## Section 3: Further guidance

### Evidence

We use the word **evidence** in the same broad sense that it is used in a committee of inquiry or in a court.

Your EqIA should name all the main sources of **relevant evidence** that you consulted. It should also give full reference details where appropriate.

There are many different kinds of evidence, ranging from academic research to personal experiences and opinions.

There are also many different ways of collecting and assessing evidence, ranging from asking people what they think (qualitative evidence, often resulting in 'soft' or 'grey' literature) to collecting precise numerical data (quantitative evidence).

There is a summary of the main types of **relevant evidence** below.

You will probably need to understand and use the distinction between **quantitative** and **qualitative** evidence.

### Quantitative evidence

**Quantitative** evidence, as the name suggests, is to do with measurable quantities and numbers.

Quantitative evidence relating to equalities in the health and social care services is mostly about:

- relative levels of health
- things that affect people's health
- life expectancy
- take-up of service
- effectiveness of services.

We give some examples on pages 34 and 35.

Quantitative evidence in the health and social system comes partly from administrative data collected by DH, the Information Centre for health and social care and other sponsored bodies, the Office for National Statistics and other government departments and agencies.

The information comes mainly from:

- commissioners and providers of health and social care e.g. primary care trusts
- local authorities
- NHS trusts
- foundation trusts
- independent sector treatment centres
- ambulance trusts
- GPs, dentists and pharmacists
- the third sector.

There are a number of ways the information is collected. It can be from specially commissioned surveys or from DH or NHS systems such as the Electronic Staff Record or the Secondary Uses Service (SUS).<sup>2</sup>

Many organisations also undertake or commission regular or one-off surveys based on representative samples such as the **Health Survey for England**, the **General Household Survey** and the **English Longitudinal Study of Ageing**, the **GP Patient Survey** and the **Care Quality Commission's Patient Survey Programme**. You can find more information about these surveys online.<sup>3</sup>

Analysis of **qualitative** data can also give additional sources of **quantitative** evidence, such as forecasts of population numbers, obesity and smoking prevalence.

As well as giving **quantitative** evidence about take-up and outcomes, you may also want to include the results of opinion surveys of various kinds.

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2 SUS provides anonymous, patient-based data for use in areas such as healthcare planning, medical research and national policy development.

3 Information Centre [www.ic.nhs.uk](http://www.ic.nhs.uk)  
Office for National Statistics [www.statistics.gov.uk](http://www.statistics.gov.uk)  
Care Quality Commission [www.carequalitycommission.org.uk](http://www.carequalitycommission.org.uk)

For example, the 2007 report of the **British Social Attitudes Survey** included articles on attitudes towards disabled people and attitudes to work-life balance.

There are some more sources of **quantitative** evidence in **Further reading** at the end of **Annex 1** on page 44.

## Qualitative evidence

**Qualitative** evidence is to do with people's experiences of services and their views.

The main **types** of **qualitative** evidence include:

- case studies and project evaluations
- literature reviews
- interviews and focus groups
- inspection reports
- views, proposals, recommendations and good practice guides
- responses to Green Papers and White Papers
- responses to draft EqIAs
- international comparisons.

The main **authors** of **qualitative** evidence include:

- research centres and units based in universities
- specialist consultancy organisations
- the Equality and Human Rights Commission
- other government departments
- DH itself
- interest and advocacy groups, including trade unions and professional associations, specialist organisations, and associations and alliances representing various areas to do with equality. (Many of the DH strategic partner organisations have access to equality evidence. You can find details on **Delphi**.)

## Sources of evidence

### Literature review

A literature review is a review of relevant literature carried out in three stages:

- a literature search and selection of relevant articles
- an assessment of the quality of the sources identified
- extraction and analysis of any data.

### LibCat searches

LibCat is a list on **Delphi** of over 200,000 references to books, official reports, articles, chapters and electronic publications of relevance to DH's business.

You can use LibCat to help you keep up to date with new developments in your subject area or to give feedback on DH policies.

### NHS Evidence searches

NHS Evidence (launched April 2009) allows you to search health-related English language publications online. **[www.evidence.nhs.uk](http://www.evidence.nhs.uk)**

You could search for 'access' and 'ethnicity' or a combination of other key words.

You could also look through paper copies of recent issues of suitable journals available from DH libraries.

### Searches of other databases

You can also search for evidence on other databases, including:

- Medline Plus<sup>4</sup>  
**[www.nlm.nih.gov/medlineplus/druginformation.html](http://www.nlm.nih.gov/medlineplus/druginformation.html)**
- Department of Health  
**[www.dh.gov.uk](http://www.dh.gov.uk)**
- King's Fund and Nuffield Institute for Health in Leeds (HMIC)  
**[www.datec.lavoisier.fr/gb/not\\_bdd.asp?bdd\\_id=279](http://www.datec.lavoisier.fr/gb/not_bdd.asp?bdd_id=279)**
- Cochrane library  
**[www.cochrane.co.uk/en/clib.html](http://www.cochrane.co.uk/en/clib.html)**
- Warwick Centre for Research in Ethnic Relations database  
**[www.warwick.ac.uk/CRER/resources.html](http://www.warwick.ac.uk/CRER/resources.html)**
- CINAHL (nursing and related studies) bibliographic database  
**[www.sandiego.edu/academics/nursing/theory/CINAHL/allen.html](http://www.sandiego.edu/academics/nursing/theory/CINAHL/allen.html)**

4 Medline Plus is a database of the US National Library of Medicine.

- National Institute for Health and Clinical Excellence database.  
[www.nice.org.uk](http://www.nice.org.uk)

If you have any problems accessing any of this information, please contact the DH Library for help. Alternatively speak to your Equality and Inclusion Team Policy Partner.

### **Identification of grey literature**

Grey literature is information that is not commercially published. It can include technical reports, working papers, results from stakeholder workshops and conference proceedings.

Some previous studies have shown the significance of grey literature to, for instance, studies of minority ethnic groups.

In order to collect relevant grey literature, you could send letters to all or selected NHS and social care departments or other organisations, asking for copies of any relevant reports (or grey literature) they might have.

You could also send similar letters to agencies you have identified from previous work or from a web search as being actively involved in developing equality and diversity focused health research.

## **Examples of the types of evidence you might use**

**Here are some examples of discrimination and inequalities faced by various groups. They illustrate the types of key facts you could include in your evidence.**

### **Access to health and social care**

- Uptake for cervical screening among women aged 18 and over with learning disabilities is 3% for those living within a family and 17% for those in formal care, compared with 85% for women aged 20–64 nationally.<sup>5</sup>
- 40% of people with a visual impairment believe that their GPs are not fully aware of their needs.<sup>6</sup>
- 24% of people who are deaf or hard of hearing miss appointments and 19% miss more than five appointments because of poor communication.

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5 *The NHS – Health for all? People with learning disabilities and health care*, Mencap, 1998

6 Nzegwu F, *The experiences of visually impaired users in the NHS: a survey*, The Guide Dogs for the Blind Association, 2004

- People from some black and minority ethnic (BME) groups are less likely to be offered psychological therapy, less likely to access mental health care through GPs and community services and more likely to access them through social services or the criminal justice system.<sup>7</sup>

## Outcomes

- The **Health Survey for England 2004** showed comparative risk factors for **cardiovascular disease** among women in minority ethnic groups compared with women in the general population. For instance, Irish and African-Caribbean women were much more likely to have high blood pressure.
- There is still a clear difference in smoking between manual and non-manual groups and there are also significant differences between different ethnicities and genders. For instance, over 40% of Bangladeshi men smoke compared with around 5% of Bangladeshi women and more than 25% of Irish women compared with 8% of Chinese women.

## Mental health

- People with severe mental illness are 1.5 times more likely to die prematurely than others, often from preventable causes.
- Gay and bisexual men are over four times as likely to attempt suicide as heterosexual men.
- The **2007 national Count Me In** census of mental health inpatients showed that black people and mixed white/black people are more likely than the national average to be admitted to a mental hospital.

## Statements to help you summarise your evidence

Using the principles and criteria for assessment you have chosen, and the evidence you have looked at, you need to make an overall assessment of the policy.

We suggest you copy and paste one of the following statements into your document, and then expand and explain it as appropriate.

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<sup>7</sup> *Count me in 2007: Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales*, Healthcare Commission, 2007

<b>A</b>	A positive impact is clearly intended and very likely.
<b>B</b>	A negative impact is unlikely. The policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist.
<b>C</b>	A negative impact is unlikely. The policy has the potential to reduce barriers and inequalities that currently exist. However, there is not enough evidence to make this assessment with as much confidence as we would like.
<b>D</b>	Negative impact is unlikely, but positive impact is also unlikely.
<b>E</b>	Negative impact is probable or certain, since some groups will be disadvantaged, either proportionately or absolutely. Remedial action is therefore necessary.
<b>F</b>	Negative impact is probable or certain for some groups, but the policy as a whole can nevertheless be justified.
<p><b>PLEASE NOTE:</b> If you select option F you will need to obtain legal advice.</p>	

# Useful contact details

Library Services, Department of Health: [library.enquiries@dh.gsi.gov.uk](mailto:library.enquiries@dh.gsi.gov.uk)

Equality and Inclusion Team: [equality@dh.gsi.gov.uk](mailto:equality@dh.gsi.gov.uk) or  
[EqIA@dh.gsi.gov.uk](mailto:EqIA@dh.gsi.gov.uk)

# Annexes

There are two Annexes to this document.

**Annex 1** is a **style guide** to writing EqlAs.

**Annex 2** explains why EqlAs are important and answers some **frequently asked questions** (FAQs).

For more background information on EqlAs, please see **Delphi**, our website [www.dh.gov.uk/equality](http://www.dh.gov.uk/equality), or speak to your Equality and Inclusion Team Policy Partner.

# Annex 1: Style guide

## Using language

1. Over time, language and words change their meanings and implications, and come to mean different things to different people.

These changes happen because:

- the world changes
  - understanding of the world changes
  - some groups and communities gain more power and influence and make their voices and viewpoints better heard and understood (for example, see African-Caribbean on page 42).
2. We use words differently in different contexts. When talking about **disability** or **ethnicity**, for example, there are often differences between:
    - legal, administrative and official use of language
    - ordinary conversation among the general public (often reflected and reinforced in the media)
    - the words that disabled people or people and communities from minority ethnic, religious and cultural backgrounds use and understand about themselves
    - academic language.
  3. **Race**, as in **race relations** and **race equality**, and **racial**, as in **racial group**, are often used in official documents referring to legislation. These words are also used in everyday conversation and in the media.

However, academics hardly every use **race** or **racial**, except in quote marks to show the terms are problematic. The term they usually use is **ethnicity**.

There are also different views, for instance, about whether you should say **disabled people** or **people with disabilities**, and about the use of the word **lesbian**.

4. It will be a long time before everyone uses the same words when talking and writing about **disability**, **race** and **ethnicity** or **sexual orientation** in the UK, let alone in the rest of the English-speaking world, or in international forums.

We cannot insist how words should always be used. We can, however, be consistent in how we use them ourselves. We can and should also explain how and why we use contested terms ourselves.

5. When writing an EqIA, we recommend that you use the conventions below when referring to race or ethnicity:
  - **African** rather than **black African**
  - **African-Caribbean** rather than **black Caribbean**
  - **South Asian** rather than **Asian** to refer to people of Bangladeshi, Indian or Pakistani heritage. Occasionally this will include a small but statistically **not** significant number of **other Asian** people
  - words like **heritage**, **background** and **community** rather than **group**
  - **ethnicity** rather than **race** (even in references to legislation)
  - **black and minority ethnic** or **BME** rather than **ethnic minority**.

Please note that not all sources of information use these terms in the same way – for instance, the Office for National Statistics.

## Myth busting

### Using words about race or ethnicity

#### Race or ethnicity

- **Race** is used in legislation, for example in the terms **race equality**, **race relations** and **racial group**. However, there is no scientific basis for dividing the human species into races.
- **Ethnicity** implies cultural, language and religious aspects of identity as well as (sometimes but not always) visible differences. This is a more accurate term to reflect the intentions in race relations legislation.

#### BME and BAME

- **BME** can be useful to refer broadly to all people not classed as **white British**.
- However, **BME** can imply uniformity when there are significant differences within and between **minority ethnic** communities. All minority and ethnic

communities are not a homogenous group for health status, disease patterns or health behaviours. They all have different needs and preferences.

- The term **BME** is therefore not helpful when referring to the practical measures needed to improve services.
- The term **BAME** (short for **black, Asian and minority ethnic**) is also sometimes used. The same issues apply as for the term **BME**.

### Asian

- Publications sometimes use **Asian** to cover Bangladeshi, Indian and Pakistani communities.
- However, these communities vary a lot in social class and migration history; recent economic trends; the geographical area within Britain where they are mainly settled; and religious tradition, culture and language. There are also differences in the type of prejudice, hostility and discrimination they may experience.
- There are few, if any, practical policies and measures that are relevant to all **Asian** communities without exception. It is therefore important to be clear about which communities you are talking about or addressing.

### Black

- Publications sometimes use the term **black**, without distinguishing between **African** and **African-Caribbean** communities.
- Documents occasionally use **black** to refer to all people who may experience racism because of their physical appearance.
- Although **black** can be useful shorthand in publicity material, policy should generally refer to specific communities such as **African** and **African-Caribbean**, or use the generic term **BME**.

### White

- **White** is used in different ways in different contexts. Sometimes, **white** refers to all people who describe themselves as **white** in the categories of the 2001 census. At other times, it refers only to those who **also** describe themselves as **white British**.
- Since terms such as **ethnic minority** and **BME** are usually defined as **not white**, it follows that they too vary in their meaning according to who is and is not classified as **white**.

## **African**

Communities with **African** backgrounds are different from one another in terms of:

- social class
- the education levels in the countries from which they came
- the length of time they have been in Britain
- the mix of push and pull factors affecting their decision to move to Britain
- religious tradition, culture and language.

Because of these differences, there are few, if any, practical policies and measures that are relevant to all **African** communities without exception.

## **African-Caribbean**

- **African-Caribbean** is sometimes shortened to **Afro-Caribbean**. **Afro** in this context means of **African origin**. Opinion regarding this term has changed and it is now offensive to many people.
- The word **Afro** most commonly relates now to a hairstyle rather than ancestry.

## **Disability**

### **Common misunderstandings**

- A lot of problems faced by disabled people are due to other people's misunderstanding of their capabilities and abilities (as opposed to disabilities). You therefore should not make assumptions about what people can and cannot do.
- Disability is not an illness. Disabled people tend to have the same sort of health (good or bad) as anyone else.
- A lot of people do not see themselves as disabled, even if they qualify under the Disability Discrimination Act, so you cannot guarantee that you will always get a response to questions about disability.
- If you want to ask someone about their disability, it may help to explain why you want to know, and to make it clear that they are not obliged to answer if they don't want to.
- There is no need to be overly sensitive about using common expressions which could be deemed to relate to someone's disability. Expressions like 'See you later' or 'I must be running along' are not usually offensive to people who cannot see or cannot run.

## Disabled/disability

- **Disabled** is the generally accepted term for describing a wide range of impairments, including:
  - **physical impairments** (such as cerebral palsy or cystic fibrosis)
  - **sensory impairments** (such as problems with sight or hearing)
  - **cognitive impairments** (such as learning difficulties)
  - **mental health conditions** (such as schizophrenia, depression or bipolar disorder).
- However, describing an individual as **disabled** can offend some people. Many people feel that the word **disabled** puts the focus too much on the person rather than on the social structures which do not allow them to reach their potential (for example, inaccessible buildings or information in inaccessible formats).
- Some people prefer the terms **disabled people** or **disabled person**, or alternatively **people with disabilities** or **person with a disability**.
- **Disabled** is therefore useful as a general term but you should be careful about using it to describe an individual.

## Impairment

- For the reasons described above, many people prefer to use the word **impairment** rather than **disability**. An example would be the term 'hearing impairment'.
- You can find more information on the **social model of disability** and how it differs from the **medical model** through the Office for Disability Issues at: [www.odi.gov.uk](http://www.odi.gov.uk)

## Labels

- As a general rule, you should avoid labels such as 'the disabled', 'the blind', 'an epileptic' as they use disability to define a group or individual and encourage stereotyping. It is better to say 'disabled people' or 'people with disabilities', 'people who are blind', 'a person with cerebral palsy' or 'with epilepsy', 'someone with a learning disability'.

## Victim

- Terms like **victim** and **suffer**, as in **cancer victim** or **suffering from AIDS**, are sometimes used in the media. These terms are disempowering.

- It is better to say **person living with HIV/AIDS**, **person with schizophrenia**, etc.
- A person **uses** a wheelchair. They are not **confined** to one.

### Sexual orientation

- The preferred terms are **heterosexual**, **gay**, **lesbian**, **gay woman** and **bisexual**.
- Some women object to the term **lesbian**, and prefer **gay woman**. In surveys etc it is therefore best to have the option **gay/lesbian** as one tick box and to identify gender separately, if required.
- Some people misunderstand the term **heterosexual**. It is best to use **heterosexual (straight)** where possible.

### Transgender

- **Transgender** is not a sexual orientation but a **gender identity**. If you need to address transgender issues you should keep them separate from sexual orientation.
- **Transgender** people have a sexual orientation just like everyone else.

#### Further reading

Equalities Review Panel (2007) *Fairness and Freedom: the final report of the Equalities Review*, Cabinet Office

<http://archive.cabinetoffice.gov.uk/equalitiesreview>

Platt, L (2007) *Poverty and Ethnicity in the UK*, The Policy Press for the Joseph Rowntree Foundation

[www.jrf.org.uk/publications/poverty-and-ethnicity-uk](http://www.jrf.org.uk/publications/poverty-and-ethnicity-uk)

Red Cross briefing note on the social model of disability

[www.redcross.org.uk/standard.asp?id=58926](http://www.redcross.org.uk/standard.asp?id=58926)

# Annex 2: FAQs

## Q1. Why do we need to consider equality?

Here are a few reasons (it is not a comprehensive list):

- DH's **Strategic Objectives** are to provide better health, better care and better value for all.
- Equality is one of the strategic priorities within the DH Business Plan 2009–11. [www.dh.gov.uk/en/Aboutus/HowDHworks/DH\\_4105906](http://www.dh.gov.uk/en/Aboutus/HowDHworks/DH_4105906)
- The goal for the NHS that the Prime Minister set out on 7 January 2008 stresses the importance of making the NHS “personal to each of us”.
- Delivering **Public Service Agreement 15**, to “address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief”.  
[www.hm-treasury.gov.uk/d/pbr\\_csr07\\_psa15.pdf](http://www.hm-treasury.gov.uk/d/pbr_csr07_psa15.pdf)
- **The NHS Constitution** says: “The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.”  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093419](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419)
- DH's commitment to **reducing health inequalities**.  
[www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm](http://www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm)

## Q2. What are we trying to achieve?

Our vision is that DH is committed to equality and will be an effective government champion for health and wellbeing for all.

We do this by:

- setting national direction and priorities, and supporting delivery of health and social care, in ways that promote equality and tackle health inequalities that result from disadvantage and damaging discrimination
- supporting people to maximise their potential by maintaining and promoting their health, wellbeing, independence, choice and control
- supporting all the people who work for DH to deliver our goals, recognising the value of their differences in the contribution they make.

### Q3. Do I really need to do an EqlA?

You **must** consider doing an EqlA whenever new policies are proposed and developed, and whenever existing policies are reviewed.

EqlAs are particularly important for high-profile policies – for example, when a Green Paper or White Paper is being written; when there is a ministerial announcement; or when there is substantial media and political interest.

### Q4. What if my policy is aimed at everyone equally?

All policy sets out to achieve a benefit. However, there is always a risk that the policy will **not** reach everyone it is intended to help, or that it will have unforeseen negative consequences.

It is usually the most disadvantaged people in society that are more at risk as they are often hard to hear, do not get all the public services they need and are vulnerable. It is therefore vital to consider likely consequences as early as possible in the policy development process, as it is easier and usually cheaper to address them at an early stage.

No matter how sound the aims of policy, if it fails to reach large sections of the population it cannot fully achieve its aims.

**Public sector equality duties** do not say “Treat everyone equally”. They are about **eliminating** unjustifiable discrimination and **promoting** equality.

Sometimes it is necessary to treat people differently in order to give them equal opportunities. For example, a person whose first language is not English may need information in a different language to have an equal opportunity of accessing it.

We know that some groups of people often have difficulty accessing health and social care services. For instance, women with learning disabilities have a very low take-up rate for cervical screening services, and almost a quarter of people who are deaf or hard of hearing miss appointments due to poor communications.

It is important to remember that the **Disability Equality Duty** requires public bodies to have due regard to the need “to take steps to take account of disabled persons’ disabilities, even where that involves treating disabled persons more favourably than other persons”.

### Q5. My policy is going to be implemented by NHS bodies, local authorities or arms length bodies, so can I leave equality impact assessment to them?

No. Both DH and other public bodies must take account of equality issues.

Policies are often decided at national level and then carried out at local level in ways that take account of local circumstances. It is rare for DH to say exactly what must happen, leaving no scope for local decision making.

In setting priorities for health and social care, DH has to take account of equality issues at national level. It is helpful to the NHS and local authorities if the work DH does sets out the equality issues. This avoids the need for local bodies to start from scratch, as they can use the information DH has already identified when considering the equality issues that arise in their own areas.

A national EqIA should also help ensure that the policy is flexible enough to be adapted to suit local circumstances, including local equality issues.

### Q6. What about procurement?

Where a contractor carries out a function on behalf of a public body, the **legal responsibility** for that function stays with the public body that contracts out the function.

However, a contract to provide services to the public may mean a contractor is involved in activities of a public nature. The contractor would then be a public authority in relation to these activities and would also be covered by equality legislation.

The Office of Government Commerce guidance on **Social Issues in Purchasing (2006)** suggests that, as there has been political agreement, the laws covering equality should be mentioned as standard.

You can find detailed guidance on equality and procurement in the OGC guidance **Making Equality Count** at: [www.ogc.gov.uk/delivering\\_policy\\_aims\\_through\\_public\\_procurement\\_social\\_issues.asp](http://www.ogc.gov.uk/delivering_policy_aims_through_public_procurement_social_issues.asp)

**Pre-qualification questionnaires** may be used to assess how well a supplier meets equalities legislation in terms of employment and in supplying goods and services.

To help improve choice, personalisation and innovation you could consider giving contracts to:

- small and medium-sized enterprises
- BME businesses
- women-owned businesses
- businesses owned by disabled people
- the voluntary and community sector.

#### **Help and advice**

For further advice on procurement, contact the Procurement, Investment and Commercial Division (formerly PCoE) through **Delphi**.

### **Q7. Who can help?**

The **Equality and Inclusion Team** can advise you on carrying out an EqIA. It is a good idea to contact the Equality and Inclusion Team early in the policy process.

At least one person from each policy team should be trained. But if your team is involved in developing a big policy initiative – for example in the run-up to new legislation or a departmental policy paper – it is often helpful for the whole team to attend together.

You can use issues you are working on as case examples to work through with the trainers.

#### **Help and advice**

The first points of contact for EqIAs are **Brenda Hardcastle** and **Monique Akosa**. Email: [EqIA@dh.gsi.gov.uk](mailto:EqIA@dh.gsi.gov.uk)

There is also training available in how to do an EqIA, including a series of masterclasses, which include equality issues as an integral part.

#### Help and advice

Look out for announcements on **Delphi**.

### Q8. What about impact assessment, health impact assessment, health equity audit, rural proofing, etc?

**Impact Assessments** (IAs) are an integral part of the policy-making process.

The purpose of an IA is to help the **policy maker** to:

- examine the policy
- ask why intervention is necessary
- ask what impact the policy change is likely to have
- highlight costs, benefits and risks.

You need to do an IA for regulations and all policies that have an impact on either business or the public sector, including those that require Cabinet Committee clearance, if they have an impact of:

- more than £20 million on the NHS
- more than £5 million on all other front-line services.

You also need to do an IA if a policy is novel or contentious – in other words, if it is likely to attract high levels of political or media interest.

#### Help and advice

You can get more advice about IAs from **Delphi**, or contact **Marie-Elaine Frith** or **Julie O’Connell**.

You will probably need to do an IA as well as an EqIA on your policy, and may well have to do other assessments too.

However, even if you do not need to do an IA you will **still need to screen your policy** to decide whether to do an EqIA on it. Many policies that do not require an IA will require an EqIA.

The focus of the different assessments is on different things, and the circumstances in which they need to be carried out are different. But you may well find that some of the material you use for one assessment is also relevant to another.

A good reason to start an EqlA **early in the policy process** is that as part of your IA you will need to consider the resource implications of any action that is needed to address potential negative impacts of the policy on particular groups.

### **Q9. How do I balance the requirement for monitoring information against the need to reduce the burden of bureaucracy?**

You need to consult your analyst or statistician and to think creatively about what information is already out there.

### **Q10. The policy I am working on is designed to focus on only one sector of the population. Does that make it incompatible with the equality duties?**

Not necessarily. Sometimes it is necessary to treat people differently in order to promote equal opportunities.

Sometimes it may be helpful to set the policy you are working on in a wider context in order to assess its impact on equality.

For example, it would not be possible to defend a decision arbitrarily to target a service (for example, screening for a particular disease) on one particular group of people. But a decision to target that group could be exactly what is needed to promote equal opportunities if there is good evidence to show that the group is at higher risk than others of developing the disease.

The **race and disability duties** require public bodies to promote good relations between people of different ethnicities and positive attitudes towards disabled people. An arbitrary decision to favour one group over others is unlikely to achieve these aims, but a reasoned one may well do so.

### **Q11. Where do human rights fit in?**

Every person is of equal value. We all have basic human rights which must be upheld. Human rights are about ensuring fairness, respect, equality, dignity and autonomy for everyone.

Everyone has the right to enjoy their basic human rights such as right to life and not to be treated in an inhuman or degrading manner, protected by the

Human Rights Act 1998. For example, there could be human rights implications if policies neglect or have a negative impact on certain groups on issues such as life expectancy and liberty.

We assess our policies for their impact on various groups because we want to uphold human rights for all.

There is more information on the Human Rights Act 1998 in **Annex 1, paragraph 1.3** of the mainstream document.

You can also get more information on human rights from **equalityhumanrights@dh.gsi.gov.uk** or your Equality and Inclusion Team Policy Partner.

